Western Pennsylvania Psych Care

Clinic Intake Form

Child_____Adult_____

DATE: _____

PATIENT INFORMATION:

Name: _____ D.O.B: _____

Address: _____

SS#: _____ Sex: Male or Female

Phone Contact Numbers: _____ _____ _____
Home Work Cell

Email Address: _____

Marital Status (If under 18, parent status): Single / Married / Divorced / Separated / NA

Employed (If under 16, parent status): No / Full-Time / Part-Time Employer: _____

Race: _____

IF PATIENT IS UNDER 18:

Mother's Name: _____ Date of Birth: _____

Father's Name: _____ Date of Birth: _____

Address: _____

Parents' Marital Status: _____ Living with: Both Parents/ Mother / Father / Other

IF OTHER THAN PARENT:

Name: _____ Date of Birth: _____

Relationship to Patient: _____

Address: _____ Phone # _____

Has the patient ever received any psychological services in the past? YES / NO
If yes, when and with whom? _____

Does the patient have any allergies? YES / NO
If yes, what to and reaction experienced?

_____

How was patient referred to our agency? _____

EMERGENCY CONTACT: _____

RELATIONSHIP TO PATIENT: _____ **PHONE #:** _____

Western Pennsylvania Psych Care

INSURANCE PROFILE

PRIMARY INSURANCE COMPANY: _____

Name of Insured: _____ Relationship to Patient: _____

Insured D.O.B: _____ Insured SS#: _____

Patient's Identification #: _____ Patient's Group #: _____

Insured's Employer: _____

SECONDARY INSURANCE COMPANY: _____

Name of Insured: _____ Relationship to Patient: _____

Insured D.O.B: _____ Insured SS#: _____

Patient's Identification #: _____ Patient's Group #: _____

Insured's Employer:_____

Western Pennsylvania Psych Care

Consent to Discuss Protected Health Information Via Electronic Communication

Patient Name_____ Date of Birth_____

Parent/Legal Guardian Name (if under 14): _____

By signing below, I permit Western Pennsylvania Psych Care to communicate protected health information for the above patient via e-mail at: _____

E-mail Risks and Your Responsibility:

You and your provider(s) at Western Pennsylvania Psych Care (WPPC) and its employees and staff have agreed to correspond using e-mail. These e-mails may contain personal protected health information including: mental health issues. You need to be aware of the risks and your responsibilities.

1. As the internet is not secure or private, unauthorized people may be able to intercept, read, and possibly modify e-mails you send or receive from WPPC. You must protect your e-mail account and password against unauthorized use. Hackers can get access to your account.
2. Viruses can be spread via e-mail and some may cause e-mail messages to be sent to unintended people.
3. E-mails can be copied, printed, and forwarded by recipients; be careful with whom you send or share e-mails.

Conditions for the Use of E-mail

By consenting to the use of e-mails with WPPC you agree that:

- WPPC may forward e-mails, as appropriate, for diagnosis, treatment, billing, and other related reasons. Employees and medical staff other than the intended recipient may have access to your e-mails.
- Although WPPC will try to read and respond to your e-mail, we may not read your e-mail immediately. If you do not receive a response within a reasonable time, it is your responsibility to contact us via phone to follow up.
- You should carefully consider the use of e-mail for communicating sensitive medical and personal information.
- E-mail messages should be short, clear, and concise.
- WPPC reserves the right to save your e-mail, including the information contained therein, in the medical record.
- You agree not to abuse the right to communicate with WPPC via e-mail and your communications will be professional in content.
- E-mail access to staff is being provided as a convenience to our patients and WPPC has the right to restrict your ability to communicate with us via e-mail at any time for any reason, including cases where WPPC reasonably believes that it is not in your best interest to continue to seek advice via e-mail and an in-person appointment is needed or that e-mail is being used excessively in lieu of in person care.

Instructions

- You should immediately inform the staff at WPPC of any changes to your e-mail address.
- E-mail should be used only for non-sensitive and non-urgent issues. E-mail is not a substitute for psychotherapy or medication management appointments.
- Please put the patients name and DOB in the body of the e-mail for proper identification.
- If you wish to withdraw your consent to communicate via e-mail you must inform WPPC in writing.

_____ _____

Signature Date

_____ _____

Witness Signature Date

Western Pennsylvania Psych Care

FINANCIAL AGREEMENT

Patient Name: _____ Birth Date: _____

INSURANCE

Any amount not paid by your primary insurance company is your responsibility, including deductibles, co-payments, and denied claims. It is your responsibility to understand which services are covered by your policy and which are not. You are also accountable to ensure that you do not exceed the yearly maximum number of visits allowed. This office will bill secondary insurance if we are given insurance information needed to do so. If any information is given to us after previous office visits have occurred it may be too late to back bill even if insurance was effective. **Any applicable co-payment must be paid prior to your session or you may not be seen for your appointment.** If you do not have insurance this applies to your self-pay fee. It also applies to any balance due on your account. It is your responsibility to inform us of any changes regarding this information. If you fail to supply us with this change of information, then you are responsible for payment of these visits.

OTHER SERVICES

Any additional services or paperwork outside of office visits such as letters, reports, phone contacts, court appearances (unless court subpoenaed), etc. are not covered by your insurance and will be billed at an hourly rate if you request said services. For any other report or letter a fee will be charged.

NO SHOWS AND CANCELLATIONS

Any patient (unless patient has Medicaid) who fails to show for an appointment will be charged a $35.00 fee for that session. A 24-hour notice is required to avoid being charged for a canceled appointment. If any patient has two or more no show/late cancel appointments there is a possibility of being discharged from the practice.

RETURNED CHECKS

A fee of $35.00 will be charged to your account for a check returned to us for Non-sufficient funds or any other reason.

NON-COMPLIANCE

Following the doctor and/or therapist's recommendations is vital to your treatment. Non-compliance of any kind is reason for termination of services. Failure to meet the terms of this agreement will be considered non-compliance.

Person Financially Responsible for Account: I the undersigned, hereby agree to be financially responsible for this account and agree to the above terms. **SIGNING THIS FORM IS FOR FINANCIAL RESPONSIBILITY ONLY. IF THE POLICY HOLDER REFUSES TO SIGN THIS FORM, TREATMENT WILL BE TERMINATED. IF THERE IS AN EXTENUATING CIRCUMSTANCE AND THE POLICY HOLDER IS UNABLE TO SIGN THIS DOCUMENT, ANTOHER LEGALLY ASSIGNED PERSON MAY SIGN TAKING RESPONSIBILITY FOR PAYMENT AND CONSEQUENCES FOR NON-PAYMENT.**

Name: _____ Relationship to Patient: _____

Social Security Number:_____ Home Phone: _____ Cell Phone: _____

Address: _____

Signature: _____ Date: _____

Western Pennsylvania Psych Care

Externally Prescribed Medications and Updates

Please list all medications client is currently on, including those prescribed by their PCP, any psychotropic medication, any herbs or supplements, and any over-the counter medications.

Medication	Date Prescribed	Prescriber	Dosage	Indications

Please list any medication updates or changes below.

Medication	Date of Change	Prescriber	Dosage	Indications

Western Pennsylvania Psych Care

Client Name: _____ **DOB:** _____

Consent for Treatment – 14 and Older

Outpatient Treatment/Medication Management

- I understand that outpatient treatment consists of regularly scheduled appointments with a therapist and/or the doctor/nurse.
- I understand that it is my responsibility to attend each appointment or reschedule in a timely manner.
- I understand it is also my responsibility to follow the recommendations of my provider and failure to do so is cause for discharge from treatment.
- I understand it is my responsibility to call for medication scripts/refills AT LEAST 72 hours in advance.
- I understand that these are voluntary services that I may discontinue at any time.
- I give my full permission to be treated by Western PA Psych Care.

RISKS AND BENEFITS OF TREATMENT:

Although psychotherapy and psycho diagnostic services have been demonstrated to be safe and effective procedures, clients may experience transient discomfort in the course of psychotherapy or diagnostic testing associated with working through difficult emotions, events, or historical material. A small number of clients may not improve as a result of therapy or may terminate before it is clinically indicated. It is important to keep your psychiatrist or therapist advised of any difficulty you may encounter in the course of your treatment or of any concerns that you may have about your treatment plans and progress.

_____ _____

Patient Signature **Date**

_____ _____

Witness Signature **Date**

Western Pennsylvania Psych Care

PRIMARY CARE PHYSICIAN RELEASE

Date: _____

Patient's Name: _____

Patient's Date of Birth: _____

- ❑ **Accept Release**
- ❑ **Decline Release**

Insurance companies require us to ask you whether we can notify your primary care physician regarding your treatment at Western PA Psych Care, Inc. Some facets of treatment, especially the prescription of medication, require coordination between health care providers. **The decision is entirely up to you** but is recommended to maintain overall good health and to help rule out any physical causes for behavioral health symptoms you may be experiencing. This release covers both written and verbal communications between WPPC you're your PCP. Please complete the bottom portion of this page. Check the appropriate line above regarding coordination of care by checking the appropriate response. This authorization will remain in effect for one year from the date of signature unless otherwise revoked by you. To revoke authorization, please submit your request in writing, ATTN: Compliance Officer.

Primary Care Physician'sName:_____

Practice Name:_____

Street Address:_____

City_____ **Telephone:** _____

_____ _____

Signature of Patient (if 14 yrs. of age or older) **Date**

_____ _____

Parent Signature (if patient under 14 yrs. of age) **Date**

_____ _____

Witness Signature (if patient under 14 yrs. of age) **Date**

Western Pennsylvania Psych Care

CONSENT TO EXCHANGE OR RELEASE INFORMATION

Permission is hereby granted to release or obtain information from:

Western Pennsylvania Psych Care
1607 Third Street
Beaver, PA 15009

TO AND FROM

Name/Company: _____
Address:_____
_____
Phone: _____

Regarding: _____ _____
Patient Name **Date of Birth**

For the purpose of: Coordination of Care

Treatment Period of: _____ - _____
(Start Date) (End Date)

Information Allowed To Be Released Or Obtained (check all that apply):

- ☐ **Psychiatric Evaluation**
- ☐ **Psychological Evaluation**
- ☐ **Medical Record**
- ☐ **School Records**
- ☐ **Social History**
- ☐ **Progress Notes**
- ☐ **Appointment related information**
- ☐ **Discharge Summaries**
- ☐ **Psychiatric assessments**
- ☐ **Treatment Plan**
- ☐ **Monthly treatment reviews**
- ☐ **Treatment History**
- ☐ **Current treatment related concerns**
- ☐ **Medical History and Physical Examination**

Method of Release: _____ **Copies Only** _____ **Verbal Only** ___X__**Copies and Verbal**

Sensitive Information:

I understand that my medical record may contain information relating to Aids, HIV, Psychiatric Care, and/or treatment for drug and/or alcohol use.

☐ I **Give Consent** ☐ I **DO NOT give consent** for use and disclosure of this type of information

---

I have read this authorization and understand the content and the purpose. I understand that I am not obligated to sign the permission for the Release of Information. I understand that I may cancel this authorization at any time

This authorization will expire 1 year from the date of signature or upon request from the consume, whichever is sooner.

_____ _____ _____
Signature of Person Giving Consent **Relationship To Consumer** **Date**

_____ _____
Consumer Signature if > 14y.o. **Date**

_____ _____
Witness Signature **Date**

Western Pennsylvania Psych Care

CONSENT TO EXCHANGE OR RELEASE INFORMATION

Permission is hereby granted to release or obtain information from:

Western Pennsylvania Psych Care
1607 Third Street
Beaver, PA 15009

TO AND FROM

Name/Company: _____
Address:_____
_____
Phone: _____

Regarding: _____ _____
Patient Name **Date of Birth**

For the purpose of: Coordination of Care

Treatment Period of: _____ - _____
(Start Date) (End Date)

Information Allowed To Be Released Or Obtained (check all that apply):

- ☐ **Psychiatric Evaluation**
- ☐ **Psychological Evaluation**
- ☐ **Medical Record**
- ☐ **School Records**
- ☐ **Social History**
- ☐ **Progress Notes**
- ☐ **Appointment related information**
- ☐ **Discharge Summaries**
- ☐ **Psychiatric assessments**
- ☐ **Treatment Plan**
- ☐ **Monthly treatment reviews**
- ☐ **Treatment History**
- ☐ **Current treatment related concerns**
- ☐ **Medical History and Physical Examination**

Method of Release: _____ **Copies Only** _____ **Verbal Only** ___X__**Copies and Verbal**

Sensitive Information:

I understand that my medical record may contain information relating to Aids, HIV, Psychiatric Care, and/or treatment for drug and/or alcohol use.

☐ I **Give Consent** ☐ I **DO NOT give consent** for use and disclosure of this type of information

---

I have read this authorization and understand the content and the purpose. I understand that I am not obligated to sign the permission for the Release of Information. I understand that I may cancel this authorization at any time

This authorization will expire 1 year from the date of signature or upon request from the consume, whichever is sooner.

_____ _____ _____
Signature of Person Giving Consent **Relationship To Consumer** **Date**

_____ _____
Consumer Signature if > 14y.o. **Date**

_____ _____
Witness Signature **Date**

Western Pennsylvania Psych Care

CONSENT TO EXCHANGE OR RELEASE INFORMATION

Permission is hereby granted to release or obtain information from:

Western Pennsylvania Psych Care
1607 Third Street
Beaver, PA 15009

TO AND FROM

Name/Company: _____
Address:_____
_____
Phone: _____

Regarding: _____ _____
Patient Name **Date of Birth**

For the purpose of: Coordination of Care

Treatment Period of: _____ - _____
(Start Date) (End Date)

Information Allowed To Be Released Or Obtained (check all that apply):

- ☐ **Psychiatric Evaluation**
- ☐ **Psychological Evaluation**
- ☐ **Medical Record**
- ☐ **School Records**
- ☐ **Social History**
- ☐ **Progress Notes**
- ☐ **Appointment related information**
- ☐ **Discharge Summaries**
- ☐ **Psychiatric assessments**
- ☐ **Treatment Plan**
- ☐ **Monthly treatment reviews**
- ☐ **Treatment History**
- ☐ **Current treatment related concerns**
- ☐ **Medical History and Physical Examination**

Method of Release: _____ **Copies Only** _____ **Verbal Only** ___X__**Copies and Verbal**

Sensitive Information:

I understand that my medical record may contain information relating to Aids, HIV, Psychiatric Care, and/or treatment for drug and/or alcohol use.

☐ I **Give Consent** ☐ I **DO NOT give consent** for use and disclosure of this type of information

---

I have read this authorization and understand the content and the purpose. I understand that I am not obligated to sign the permission for the Release of Information. I understand that I may cancel this authorization at any time

This authorization will expire 1 year from the date of signature or upon request from the consume, whichever is sooner.

_____ _____ _____
Signature of Person Giving Consent **Relationship To Consumer** **Date**

_____ _____
Consumer Signature if > 14y.o. **Date**

_____ _____
Witness Signature **Date**

Western Pennsylvania Psych Care

Reminder Call Permission Form

Patient Name_____ Date of Birth_____

As a courtesy to you, we provide reminder calls for your appointments here at our office with your doctor and/or your therapist. Government regulations necessitate us to request the following:

_____ I **DO** want Western PA Psych Care to make reminder calls to the
(Initial) phone number designated below.

Phone number: _____

Do we have your permission for office staff to leave a message? Yes No

_____ Please **DO NOT** call and remind me about any of my appointments at Western PA Psych Care.
(Initial)

Again, this is a courtesy that we provide**. It is your responsibility to remember your scheduled appointments and you should not rely on this service**. It is also your responsibility to update any changes in your phone number with the office staff.

_____ _____

Parent/Guardian OR Patient Signature Date

Western Pennsylvania Psych Care

Acknowledgment of Review and Receipt

Please review the attached packet labeled “Patient Copies”. After review, please initial for each item, stating that you have read the provided information and have been provide a copy for your records.

_____ Complaint Procedure and Family Choice Notification

_____ Notice of Financial Agreement

_____ Privacy Notice

_____ Retention and Disposal of Medial Records Policy

_____ Client Rights and Responsibilities

_____ Mandated Reporter Policy

_____ No Show/Late Cancellation Policy

I, _____, have received and reviewed all of the above indicated documents.

Patient Name: _____ DOB: _____

Responsible Party Signature: _____ Date: _____

Printed name of responsible party: _____

Relationship to patient: _____

Witness Signature: _____ Date_____

Western Pennsylvania Psych Care

PATIENT PACKET

PLEASE KEEP FOR YOUR RECORDS

Western PA Psych Care • 1607 Third Street • Beaver, PA 15009 • Phone: 724-728-8411 • Fax: 724-728-8410

Western Pennsylvania Psych Care

Complaint Procedure and Family Choice Notification

In the event that I have concerns about my treatment, treatment staff, or feel that a decision is unjust and I am unable to resolve the incident with my direct staff, I may appeal to the staff member's immediate supervisor, or the Compliance Manager, Jackie Skinner at 724-728-8411. If the staff is the Compliance Manager, I may appeal to the Clinical Director, Tara Roland at 724-728-1666. I further understand that should I not be satisfied with the final decision of the Agency, I may notify my insurance company directly.

The Joint Commission office of quality monitoring may be contacted if there are complaints or concerns that are not sufficiently addressed or resolved by agency management.

Call 1-800-994-6610 or e-mail: complaint@jointcommission.org

Clinical Director: Tara Roland, MA, LBS Phone: 724-728-1666

Compliance Manager: Jackie Skinner, MSW Phone: 724-728-8411

At this time, I have chosen **Western Pennsylvania Psych Care (**WPPC) as my provider. I understand that I may change providers at any time and that WPPC is obligated to assist me with any such changes. I further understand that these services are voluntary and I may discontinue them at any time.

***This form is for client to keep for their records**

Western Pennsylvania Psych Care

Notice of Financial Agreement

Please be aware that all components of the Financial Agreement that have been signed and agreed to will be strictly enforced. Important parts of this document that we want to bring to your attention include:

- Any applicable co-payment or self-pay agreed amount must be paid PRIOR to your scheduled session or you may not be seen for your appointment.
- A payment must be made toward any current balance on your account prior to any scheduled session.
- You are responsible for all insurance deductible's; this amount WILL NOT be negotiated down under any circumstances.
- A 24-hour notice is required to avoid being charged a fee for a cancelled appointment.
- If you have 2 or more No Show/Late Cancel appointments, you are at risk for being discharged from all services received through Western Pennsylvania Psych Care.

If you need to discuss any issues related to a current balance, please inform the receptionist and we will arrange for you to discuss this matter in private with a member of our billing department.

Thank you for your cooperation and understanding.

Western Pennsylvania Psych Care

POLICY 06-17

Notice of Privacy Practice

Purpose: Establish policy regarding notice of privacy practices

Policy: Clients will be informed in writing and verbally at the time of intake on Western Pennsylvania Psych Care's Notice of Privacy Practices.

NOTICE OF WESTERN PA PSYCH CARE'S PRIVACY PRACTICES

This notice describes how protected health information (PHI) about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

Western Pennsylvania Psych Care (WPPC) uses and discloses information about you to facilitate continuity of care, treatment, payment, and health care operations. Both Federal[1] and State laws govern how information is used and stored, what information is disclosed, and who gets this information. We will only disclose information about you that we are permitted to disclose.

For treatment purposes, we will not disclose information about you without your written authorization except to facilitate continuity of care and in circumstances that we reasonably believe are emergencies. We, for example, may collect and share medication and treatment information with a primary care provider to coordinate behavioral and physical health care. Or, we may disclose information about you if you are in a hospital emergency room, and hospital staff request information to help them evaluate or treat you.

To receive payment for services, we disclose information to Pennsylvania Medicaid or any other insurance payor that determines your eligibility, enrolls you in your county's behavioral healthcare plan, and pays us for services.

Health care operations refers to quality assurance, audit, accreditation, licensing, and other activities that are required to meet our professional and legal obligations. For example, an auditor may see information about you, but we require that auditors agree to our privacy policies.

All information will be kept confidential, consistent with state and federal laws. Name identifying information will be used only to obtain payment for services provided to you. Demographic information will be kept without your name attached and reported to the state departments. This information will not be available to other sources or used for other purposes. Billing information will only be kept for up to seven (7) years after you have received services, and only demographic information will be kept after that time.

We maintain an electronic database of health information, for billing, planning, and quality assurance purposes. Your information may be seen by those who install and service our computer equipment. All business associates who provide us with services that help us operate are notified that information they see must be protected, and not disclosed.

It is your right to request that we restrict how your protected health information is used or disclosed.

We may be requested to disclose health information to authorized public health authorities for the prevention or control of disease, injury, or disability without you prior consent.

We are required to disclose health information to a government office authorized by law to receive reports of suspected child abuse or neglect. If we believe that you may be a victim of abuse, neglect, or domestic violence, we may disclose information about you to a government authority, social service agency, or protective service agency authorized by law to receive reports of this kind.

We may disclose information if we believe that disclosure is necessary to prevent serious harm to yourself or others.

We may disclose information in response to a court order, subpoena, law enforcement official's request, coroner's request, or other lawful process in which disclosure is authorized.

We may make telephone calls or send letters to you to reschedule or remind you about appointments, make arrangements for follow-up services, or provide you with information about treatment alternatives, benefits, or services. Please let us know your preferred method of communication to receive information from us through other means, or at another location. We will accommodate reasonable requests.

You have the right to inspect and copy certain health information, to request that we amend health information about you that you believe is inaccurate or incomplete, and to receive an accounting of certain disclosures of your health information. To exercise these rights, contact the Compliance Manager, Jackie Skinner. You can contact her directly by phone, fax, or standard mail at Western Pennsylvania Psych Care and even by email (jskinner@wpapsych.com). She is available all weekdays from 9 am to 5pm.

All other uses and disclosures of health information about you will be made only with your written authorization. We are required by law to maintain the privacy of protected health information, and to provide you with notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of this notice, but we reserve the right to change the terms of this notice, and to make the new notice provisions effective for all protected health information we maintain. If we change this notice, a revised notice will be made available to you. If you believe your privacy rights have been violated, you may file a complaint.

Beaver County Behavioral Health 1080 8th St. Beaver Falls, PA 15010 Phone: 724-891-2827	**Beacon Health Options** P.O. Box 1840 Cranberry Township, PA 16066-1840 Phone: 877-615-8503
The Joint Commission One Renaissance Blvd. Oakbrook Terrace, IL 60181 Phone: (630) 792-5000	**The U.S. Department of Health and Human Services** 200 Independence Avenue, S.W. Washington, D.C. 20201 Phone: 877-696-6775

You may also file a complaint in writing or electronically to the U.S. Department of Justice, Civil Rights Division, Office of the Assistant Attorney General, 950 Pennsylvania Avenue, N.W., Washington, D.C. 20530. Your complaint must be filed within 180 days of when you knew or should have known of the occurrence of the act or omission that is the subject of your complaint. You will not be retaliated against for filing a complaint.

Please keep this Notice of Privacy Practices for Protected Health Information. You have the right to review this Notice before signing the Consent for Treatment, Release of Information (to WPPC), or Request to Restrict the Release of Information (by WPPC) You always have the right to withdraw any consent, release, or request by submitting a written request to Western Pennsylvania Psych Care

---

[1] Health Insurance Portability and Accountability Act (HIPAA) privacy rules -- Title 45 of the Code of Federal Regulations, Part 164.520 -- govern the security and privacy of health information.

Western Pennsylvania Psych Care

POLICY 07-05

Retention and Disposal of Medical Records

Policy: All clinical files will be maintained, released, and disposed of by Western PA Psych Care in accordance with State and Federal regulations including, but not limited to, 45 CFR §164.306-310 and 28 PA Code §115.21-23 and §115.27-29

Record Retention

1. **For adult clients** (18 years or older), all clinical records will be retained by Western PA psych Care for 7 years post discharge. After 7 years, the company reserves the right to have any medical documentation destroyed.
2. **For minor clients** (17 years and under) who were discharged prior to the age of maturity, all clinical records will be retained for 7 years post age of majority (i.e. has reached his/her 22nd birthday). After this time, the company reserves the right to have any medical documentation destroyed.
3. I**nactive medical records** shall be maintained in a secured area within the building where treatment occurred for a minimum of 7 years and then may be transferred off-site to either Western PA Psych Care's Main Office location or another secured location. Western PA Psych Care reserves the right to contract with an information management company for both maintenance and destruction of records. For these purposes, 'secured' shall mean that a double locking system will be used and access is restricted to treatment staff, medical or clinical director, and office managers.
4. **Active medical records** are stored in an area, that is segregated from treatment and waiting areas and clearly marked '*Employees Only'*. This area shall remain staffed during normal operating hours and access to records will be monitored by designated office staff. Records will be accessed and utilized in a manner that is compliant with Western PA Psych Care Privacy Policy (03-27).

Release of Medical Records

1. If the client desires access to their medical records within the time the records are retained, a written request must be made to the director of the agency, including the client's full name and Date of Birth. A copy of the record will be made and reviewed with the client prior to release by the Clinical Director or another designated clinical staff person. Patient (or parent/guardian if under age 14) may obtain a copy medical record in full or in part free of cost. A fee may be applied for copies provided to anyone other than the patient, not to exceed the standard, maximum allowable rate.
    a. If the pateint requests information **from an active medical record** to be released to a 3rd Party, Western PA Psych Care will provide a copy via fax or US Postal Mail within 7

business days, with client's written Authorization. A record of releases shall be kept in the client's record along with the client's written authorization.

b. If the client requests information to be released from an **inactive record** and it is within the 7-year retention window, Western PA Psych Care will require the client to provide a written request. Client will be required to sign an authorization for the release of information that shall include: requested clinical documents, purpose of release, as well as intended recipient. Client will be provided with copies of the medical record in part or in full within 30 business days of written request.

Disposal of Records

1. Western PA Psych Care will dispose of inactive, medical records that have been retained for a minimum of 7 years through full destruction that may include shredding or burning. Western PA Psych Care reserves the right to contract with a 3rd party Information Management Company for the purposes of record destruction.
2. All staff who destroy or oversee the destruction of medical records shall be trained in accordance with 45 CFR §164.306 (a) (4), 164.308 (a) (5), and 164.530 (b) and (i). This shall be applicable to volunteers and interns as well as employees.

Western Pennsylvania Psych Care

Client Rights and Responsibilities

Client Rights:

1. I have the right to be treated with consideration and respect for personal dignity.
2. I have the right to privacy and confidentiality.
3. I have the right to fair treatment regardless of race, religion, gender, gender identity, ethnicity, age, disability, sexual orientation or source of payment.
4. I have the right to the rights and privileges granted by State and Federal law.
5. I have the right to participate with my treatment provider in decision-making regarding treatment planning.
6. I have the right to voice a complaint or appeal should a dispute arise over treatment or billing claims.
7. I have the right to candid discussion of appropriate medically necessary treatment options for my condition(s), regardless of cost or benefit coverage.
8. I have the right to receive and examine a detailed explanation of my bill.
9. I have the right to refuse any medications or treatments, to the extent permitted by law. The provider will inform me of any consequences of refusal of such treatment or medication.
10. I have the right to freedom from unnecessary restraint or seclusion if such restraint or seclusion is within the control of Western Pennsylvania Psych Care.
11. I have the right to be advised and refuse observation by techniques such as one-way vision mirrors, tape recordings, television, movies or photographs, unless ordered by the court, in which case the client must be informed of such techniques.
12. I have the right not to be discriminated against due to a status of being HIV positive or having AIDS.

Client Responsibilities:

1. I have the responsibility to provide, to the fullest extent possible, information that my practitioner(s) need in order to care for me.
2. I have the responsibility to follow the plans and instructions for care that I have agreed upon with my treatment provider.
3. I have the responsibility to keep my treatment provider up to date on all medications and treatments that have been provided or recommended by a source outside of Western Pennsylvania Psych Care.
4. I have the responsibility to participate, to the fullest degree possible, in understanding my behavioral health problem and developing mutually agreed-upon treatment goals.
5. I have the responsibility to inform my provider of changes in my address, phone number, and insurance coverage.
6. I have the responsibility to keep scheduled appointments and comply with my treatment provider's attendance policy.
7. I have the responsibility to comply with and undergo any testing including, but not limited to, blood work and urinalysis to monitor my dedication and condition.
8. I have the responsibility to be courteous to other patients in the office and staff members of Western Pennsylvania Psych Care.
9. I am responsible for payments for any services provided either through my insurance company and/or myself.

Western Pennsylvania Psych Care

POLICY 06-24

Mandated Reporting

Policy: Western PA Psych Care shall report all qualifying incidents of child abuse, neglect, or serious endangerment per mandated reporter requirements under 23 Pa.C.S. § 6311 occurring during a staff's shift and/or involving a client under the care of WPPC, or any child, regardless of client status, whose abuse is witnessed by or reported to staff under the employment of WPPC at the time of the incident. The procedure is as follows:

Procedure: Staff will complete the report of abuse via the on-line reporting portal OR through a Child-line within 24-hours of witnessed abuse or report of abuse. Staff shall complete necessary mandated reporting forms as well as applicable County and/or internal incident reporting forms within 24 hours of a Child-line. Staff must inform Clinical Director and/or Compliance Director as soon as possible, and not to exceed 48 hours of reporting, after a report has been filed. Reports will contain, at minimum, the following information:

- The names and addresses of the child and the parents or other person responsible for the care of the child, if known.
- Where the suspected abuse occurred.
- The age and sex of the subjects of the report.
- The nature and extent of the suspected child abuse including any evidence of prior abuse to the child or siblings of the child.
- The name and relationship of the persons responsible for causing the suspected abuse, if known, and any evidence of prior abuse by those persons.
- Family composition.
- The source of the report.
- The person making the report and where that person can be reached.
- The actions taken by the reporting source, including the taking of photographs and X-rays, removal or keeping of the child or notifying the medical examiner or coroner.
- Other information which the Department of Public Welfare may require by regulation.

The lead clinician must be notified of all incidents involving subordinate staff immediately. Designated office staff will fax incident reports to the managed care organization representative, county case manager, and County CYS office. A copy of the report will be kept in a file separate from the client medical record.

Western Pennsylvania Psych Care

Policy 06-25

Non-Compliance with Treatment Received at the Beaver Office

Purpose: To establish criteria for non-compliance with treatment that may lead to being discharged from the agency.

Policy: A client who has no-showed or late cancelled 3 appointments in a 6-month period, for any services received within the agency, will be considered non-compliant, and will subsequently be discharged from medication management and clinic-based outpatient therapy. The client will no longer be eligible to receive future services from the Beaver or Baden Outpatient Offices.

Procedure:

Missed Appointment #1: A no-show letter is sent from the front office explaining the no-show policy and that if they no-show additional appointments or have late cancellations, they are at risk for discharge from therapist and medication management.

Missed Appointment #2: A second no-show letter is sent from the office explaining the no-show policy and that if they no-show additional appointments or have late cancellations they will be discharged from therapist and medication management.

Missed Appointment #3: A discharge letter outlining the dates of the three no-shows or late cancellations is sent along with a list of additional service providers for them to utilize to obtain future treatment. If the client is receiving medication management, a 1-month prescription is provided.

Western Pennsylvania Psych Care

Western PA Psych Care • 1607 Third Street • Beaver, PA 15009 • Phone: 724-728-8411 • Fax: 724-728-8410